

THE

# BOSTON MEDICAL AND SURGICAL JOURNAL.

NEW SERIES.]

THURSDAY, FEBRUARY 11, 1869.

[VOL. III.—No. 2.]

## Original Communications.

### CASE OF CUTANEOUS HORN OF THE EYELID.—(WITH CUT.)

By HENRY L. SHAW, M.D., Boston.

THE following is the history of a cutaneous horn of the eyelid, which although not differing pathologically from those occurring on other parts of the body, would seem from its location and size to deserve a permanent record.

J. C. came to the Mass. Charitable Eye and Ear Infirmary Dec. 17th, 1868. Aged 56. Irish. Laborer. A vigorous looking man; has always been healthy. Parents were long lived; neither they nor any of his relatives have had cancer or any growths similar to the one with which he is troubled. About six years ago, there was noticed on the middle of the free border of the lower lid a small pimple, which slowly increased in size. On its anterior surface there soon appeared a fine, hair-like outgrowth, which he described as having been very hard. This continued to grow, gradually assuming the appearance of a horn, until a year and a half ago, when it was about one inch and a half in length, and about the same in circumference at the base. It then, without any apparent cause, dropped off, leaving the pimple as at first. It had not been troublesome beyond the inconvenience of it, either during its growth or at the time of shedding. It had never been inflamed, and had received no treatment.

The present growth started, in a few days, from the same point as the previous one. It, however, grew more rapidly; and in a few months it attained the same size for which, in the first instance, the growth of years had been required. Since that time it has ceased to grow.

It has been of but little inconvenience till the present winter, when the weight of the horn has produced partial eversion of the lid and consequent displacement of the lacrymal punctum, thus causing considerable trouble from the overflow of tears. The jerking motion given to the horn dur-

ing nictation has given rise to a pricking sensation and fatigue of the lid.

The horn was firmly attached near the middle of the lower lid of the right eye, just below the tarsal cartilage, with which, however, it had no connection. It was curved, and looked not unlike the beak of a bird. It measured, over the superior curve, an inch and three quarters. In circumference at the base, it was an inch and seven eighths. The outer portion, for an inch or more, was of a brownish color, rough, and longitudinally furrowed, very hard, and horny in appearance. The end was blunt, the point having been snipped off with scissors. The inner fourth was more the color of the skin, elastic to the touch, and of about the density of cartilage. The base, when examined from the inside of the lid, had the appearance of being filled with sebaceous matter.

The removal of the horn was effected by making a circular incision around the base, care being taken to avoid the tarsal cartilage and hair-bulbs, and also to preserve as much of the healthy skin as possible. The base was quite firmly imbedded, but was readily separated with the scalpel. It was thought that the edges of the wound, which was circular, might be brought together vertically by a free dissection of the flaps. But on trial this was impracticable, on account of the corrugation and eversion of the lid which it produced. A single stitch was therefore introduced a little below the middle, and the upper portion, triangular in shape, was left to granulate.

The second day, the stitch was removed. The rest of the wound healed very readily.

Jan. 1st, 1869.—The cicatrix is quite small. There is slight eversion of the lid, which may be remedied by a plastic operation, should it increase.

Cases like the above are of extremely rare occurrence. In the works of Stellwag, Wecker, Wells, Mackenzie, and numerous other ophthalmologists, no mention is made of the subject. Haynes Walton, in his admirable work on the Surgery of the Eye, speaks of "having met with a few specimens of inspissated sebaceous matter on the

edges of the eyelids, but they have all been small, time being wanting to give them the more marked characteristic horny appearance to which they owe their name." In a monograph entitled *Des Tumeurs des Paupières*, by H. Thomas, reference is made to a case of Ph. Boyer's, cited in *Traité Élémentaire de Pathologie Externe*, by E. Pollin. On looking at the original report of the case, however, it was found that the horn was situated upon the cheek, and not upon the lid. In the same work of Thomas, a case of Deval's is also mentioned. But the seat of this tumor is described as being on the brow, and he calls it a wen. We quote his own description of the case:—"Des tumeurs de tout genre peuvent se développer dans la région du sourcil. Une petite loupe qui y était située et dont je pratiquai l'extraction fournit une concrétion calcaire d'un blanc grisâtre et du volume d'un gros pois." South, in the American edition of Chelius's Surgery, says:—"Horns have been observed on the eyelids by Voisin; on the lachrymal caruncle by Chavane; and on the conjunctive coat and tongue by Breschet. The works of the first two authors we have been unable to find. Breschet, when speaking of horns, simply says:—"Ainsi, j'en ai observé sur la langue, sur la membrane conjonctive." He does not mention any cases.

The only case recorded, so far as we have been able to ascertain, of a horn growing from the eyelid, is one to which our attention was drawn by Dr. H. F. Damon, who has investigated the subject with great care. It occurred quite recently, in the practice of Dr. Joussanne, and is published in a monograph by A. Eloffe, entitled *Histoire Naturelle des Cornes*. We append an abbreviated translation of this case.

There came to my office, in 1865, a pale child, five years of age. The child presented, on the free border of the upper lid of the right eye, a horny appendage, truncated, wrinkled, and from a centimetre to a centimetre and a half in length; and of the size of a pipe-stem. By the aid of lateral traction, I removed the small body without difficulty. It was of the shape of a thimble. The wound was cauterized with nitrate of silver, to prevent its re-production. Some days after, it was cauterized again, and it was only cured after the fifth application.

In 1866, the child was presented again, for two similar growths on the upper lid of the other eye.

#### A CLINICAL LECTURE.

MEMBRANOUS CROUP; TRACHEOTOMY; DEATH IN 37 HOURS. OCCURRING IN THE PRACTICE OF C. E. BECKINGHAM, M.D.

Reported by GEO. W. GAY, M.D.

J. B., aged 7, a smart, healthy little fellow, of healthy history and parentage, got wet, Wednesday, Dec. 16th, 1868. On returning from school, where nothing unusual was noticed, he was dull and languid, and had a slight cough, which was unlike anything ever noticed in him before in its harshness and peculiar ring. He ate a little supper, went to bed, and passed a fair night. On Thursday, the cough was no worse, but his general condition was not improved.

Friday, very much better apparently; almost no cough.

Saturday, thought to be about well, and had a hot bath at night. Hitherto he had complained of nothing, and seemed to the parents to be suffering from an ordinary "cold," and received only the ordinary domestic treatment.

Sunday, Dec. 20th.—Was thought to be worse; in the afternoon, Dr. Buckingham was called to him, and found him as follows:—Pulse 120; resp. about 30; respiratory muscles of chest and abdomen in strong action; tongue dry; right tonsil swollen, red and dry, as was also the rest of the fauces. No membrane to be seen.

R. Morph. sulph. gr. ss.  
Potass. iodidi gr. viij.  
Syr. aurant. cort. q. s.  
ad ℥iiss. M.

Dose, teaspoonful every four hours till quiet.

Monday, Dec. 21st, morning.—Pulse rapid; respiratory muscles in strong action; skin livid; large muco-purulent collections in the fauces, which he expectorates on being told. No membrane in sight. Discontinue R., and give a teaspoonful of syrup of ipecac. every hour.

11, A.M.—Seen by Drs. Buckingham and Cheever. Pulse 140, slightly intermittent; resp. 36; moist râles in both chests; percussion normal; severe spasm of epiglottis, and all external respiratory muscles in strong action. Teaspoonful of syrup of ipecac. every ten minutes till he vomits.

1, P.M.—Has taken medicine regularly, and vomited a little twice. Pulse 144; resp. 36; great muco-purulent expectoration; skin less livid. Continue syrup of ipecac. every fifteen minutes.

9, P.M.—No membrane to be seen in posterior part of pharynx, but a few white

spots, appearing like the secretion of the follicles, are seen on each tonsil. Pulse 140, feeble; resp. 32, and very laborious.

9 $\frac{1}{2}$  P.M., Dec. 21st.—Operation by Dr. Buckingham, assisted by Dr. Cheever and the writer. Ether administered, with little or no effect upon the respiration. Operation performed in the usual manner. Hemorrhage moderate. As soon as the trachea was opened, a forcible expiration threw out several strips of a tough, stringy membrane. Tube secured in the trachea, and hemorrhage ceased. Patient put to bed, with the pulse at 140; resp. 20, easy and regularly irregular—i. e., an interval between every three respirations. The temperature of the room was kept between 72° and 76°.

12.30, A.M., Dec. 22d.—Asleep. Pulse 150, regular, stronger than before the operation; moist tracheal râles; sibilant râles in left lung. Tube lined with a little of a mucopurulent substance, which dries quickly and is difficult to remove. Slight subsultus in forearms. Takes milk freely. Teaspoonful of wine every hour.

3, A.M.—Awake. Urine free (3ijj.—3iv.). Pulse 160, a little irregular; resp. 32, quiet and deeper. No cough, and no secretion in the tube. Vesicular respiration in right lung. Subsultus increasing. Strength failing. Continue wine and milk.

8.30, A.M.—Patient seen by Dr. B. Pulse 160, regular; resp. 34; moist râles in trachea and both lungs. No subsultus. Dr. B. ordered a few drops of warm water to be injected into the trachea to loosen the secretion, and the patient to breathe through a moist sponge.

11.30, A.M.—Pulse 142, of fair strength; resp. 26, easy. A little of the secretion is ejected after using the water. No membrane is to be seen. He jumps up with alacrity to take his drink.

2.45, P.M.—Pulse 160, not quite so strong; resp. 52, very laborious, and free from râles in trachea and right lung; left lung full of moist râles. Water in trachea does not loosen the secretion. Skin hot, dry, and livid. Respiratory muscles in strong action and face covered with sweat. Ordered ammon. carb. gr. ij. every two hours.

6.15, P.M.—Sitting up in bed, and eating bread and milk. Tube dry. Pulse and resp. as before. Seen by Dr. B., who ordered a weak solution of common salt to be thrown into the trachea, and the wine to be omitted. Continue ammon. carb. and milk.

1, A.M., Dec. 23d.—Pulse 170 and up-

wards, and difficult to count; resp. 42, more laborious; both lungs full of moist râles. Cannot cough. Urine free. Not so strong as at last report. Ammon. carb. gr. ii. every hour.

7.45, A.M.—Has been pretty quiet since last report; has taken food and medicine regularly. Pulse 148, regular and stronger; resp. 42, regular, but no easier. Has passed a teaspoonful of urine at three different times. No distention of the bladder. Tube dry and clear; has required cleaning only once in six or eight hours. Salt water has lost all effect in softening the secretion. Neck swollen from emphysema. Skin very livid. A little restless. Teaspoonful of prescription of Dec. 20th given.

10.10, A.M.—Skin not quite so livid; resp. 34, no easier. Gets up on his elbow to drink his milk and medicine. Has refused nourishment but once since the operation. Mouth and wound lined with a thin layer of a dry grayish substance. Emphysema extends over chest and abdomen into scrotum. Legs purple.

10.30.—Dead, 37 hours after operation.  
Boston, January 19, 1869.

#### FISTULA IN ANO.

Read before the Suffolk District Medical Society, Dec. 26th, 1868, by JOHN P. ORDWAY, M.D.

PROBABLY no disease to which the human organism is prone, from the days of Hippocrates down to the present time, has developed more diversity of opinion among surgeons, as regards treatment, location, or extent. It is not my purpose in this paper to speak at length of the location of the rectal orifice of the complete fistula, which Desault, and many of the ancient authors, contended would be found sometimes in close proximity to the anus, and at other times at a considerable distance from it, while Ribes, Larrey, Sabatier, Boyer, Richer, and Brunel of Avignon (who wrote a special treatise on fistula in 1783) and others, contended that the orifice was situated just above the external sphincter. Nor will I mention those authors who believed there were no internal or external blind fistulas; but will speak of what seems to me a rational treatment, which experience and careful investigation for the past four years have led me to believe the only true treatment for the radical cure of "fistula in ano."

In doing this, I start with the positive assertion, that in my judgment the knife, so often used by surgeons with salutary

effect in other diseases, should never be used in this. To build up and repair, without destroying, sound tissues and muscles, upon which organs in the immediate vicinity are dependent, should be, it seems to me, the duty of every physician and surgeon. What should we say of the plumber, who, because the waste pipe had burst in some part, should advise opening the entire pipe, so that the filthy contents could spread all around, doing damage to everything with which they come in contact? Would he not rather attend to the locality from which the leakage proceeded?

Now, what is the character of the canal of a complete fistula, and why is it so difficult to cure? The walls of the canal are lined with what Laënnec calls "analogous accidental tissue," sometimes almost cartilaginous. There is also a mucous secreting surface, more or less induration, and a discharge of pus, or of feculent matter from the bowel. In fact, several cases I have had under treatment have been so caloused that I could trace the extent of the whole canal by external digital examination.

The first thing indicated then, it seems to me, is, to remove the induration of the mucous membrane of the canal. How is this to be done? Certainly not with the bistoury, for you remove nothing by the cut; you merely divide, without destroying the preternatural surrounding tissue. Besides, you destroy the action of the sphincter, turn the whole mass of diseased tissue and cellular structure into one common drain, and then ask nature to assist in healing; while every evacuation from the bowels causes undue irritation, and removes whatever applications may have been made for the cure of the disease, for the time being, which in my judgment is a strong reason why this method of treatment so seldom fails of cure.

What, then, is indicated in the treatment? First, destroy the mucous membrane, and the induration of the fistulous canal by direct applications, either of tents, or through the syringe, governing yourself by the extent of inflammation, and by the feelings of the patient, at the same time using proper antiphlogistic and alterative remedies to assist nature in the cure; never allowing the fistula to heal except from the internal opening, or until the whole character of the discharge has changed. I have tried many remedies for direct application, such as solutions of muriate of iron, sulphate of zinc, carbonate of potash, nitric acid, iodine, chloride of zinc, &c., varying the remedy

according to circumstances, using nothing for any length of time which will destroy healthy tissue, but using such things as tend to remedy the abnormal condition of the parts. The loose character of the cellular structure in the ischio-rectal region, no doubt, to a certain extent prevents the healing of the parts after an abscess.

Should the ligature ever be used?

I take the ground that every case is curable without it; but if used, it has this advantage over the knife, that, if not drawn too tightly, the fibres of the sphincter muscle unite, almost as fast as they are separated, and thus the risk of dividing the muscles and parts at once (perhaps producing permanent injury for life), is avoided. But the ligature should never be applied until the callus is entirely removed. I have tested this manner of finishing up the work of cure in two cases which came under my care, more to satisfy myself, than because I believed a cure could not have been effected without it. In eleven cases of complete fistula; three cases of external blind fistula; and two cases of internal blind fistula, treated by me during the past eighteen months, I have been successful without the ligature.

The five-stranded hair ligatures, of Hippocrates; or packthread besmeared with escharotic, of Celsus; or twisted hair and hog's bristles, of Avicenna; or waxed hempen thread, of Flajomi, or knotted cord of Salicet, might have been of some service, had their employers first prepared the hardened walls of the fistula by direct applications to bring about a change in the character of the secretions. "*Eccentric Compression*," "*Incision*," and "*Excision*" have all had their advocates in ancient times, without any good practical result in support of their theories.

The caustics, too, used by charlatans in the last century, and at the present day, under the guise of secret remedies, might possibly have been of some service, provided they had not been of such extreme potency, as to destroy healthy surrounding parts. There is no doubt in my mind that the theory of direct local applications to the diseased parts is correct; the great point to be gained is, to change the character of those applications from time to time, as circumstances may warrant, and we shall then get good practical results. The same principle will apply to the healing of any chronic ulcer. We have at least this advantage over the charlatan, that we gain time, and accomplish in days that which, if successful at all, he requires weeks to attain.



Should *phthysical patients* be treated? I can see no reason why they should not. It is contended that fistula acts as an *exulory*; that it would be wrong to dry up the outlet of the fountain at the risk of increasing the primary phthysical disease. The arguments often used by writers on this subject, are, that fistula moderates the progress of pulmonary disease; that it is usually caused by the ulceration of tubercles; that the wound rarely heals up, and by its abundant suppurative acts in an injurious manner upon the system; that if by chance the wound should heal, the pulmonary disease rarely fails to become aggravated.

Nélaton says, "I never hesitate to operate unless the affection of the lungs be very far advanced, and in such cases I am unwilling to operate, *not because I think the operation will do harm to the chest, but because the incision does not heal, so that it is not worth while to operate.*"

In this connection, I would say, a patient of mine was cured of a complete fistula, who, when she first came to me, had well-marked phthysical symptoms. After the fistula was healed, her phthysical troubles left her entirely, and she is now in the enjoyment of perfect health.

I should not hesitate in any case of pulmonary disease to use the treatment laid down in this paper, because I believe that oftentimes fistula, through resorption into the general circulation, is the cause of pulmonary trouble, instead of a remedy for it.

Granting that fistulas do sometimes heal spontaneously, it is only by an exception to the rule, and it may be questioned whether the result has not been due to the fact that the constitution of the person possesses recuperative power enough to combat the disease in a natural way.

The advantages of this mode of treatment over the knife, in pulmonary disease, and in fact, in all forms of "fistula in ano," are these.

1st, The avoidance of the subsequent shock of the operation, as the physician can be governed by the feelings of the patient in making the applications. 2d, The immunity from excessive suppuration. 3d, The destruction of the hardened membrane of the canal without injuring surrounding healthy tissues; and 4th, Because the disease generally occurs in persons of unhealthy organism, who have not the power to stand the excessive drain made upon the system by the operation, and who with this treatment are more likely to obtain a perfect cure. I do not believe it is a surgical disease, or that it comes within the province of surgery.

In presenting this communication to my professional brethren, I do it in no spirit of egotism, nor with any desire to break down long established theories, except so far as they seem to me erroneous. I believe no physician who thoroughly tries this method faithfully will be disappointed in the result. I speak with confidence, when I say that experience has proved to me that "Fistula in Ano" can be treated without the knife, in all cases, with better results, and less risk of permanent injury to the patient.

#### MALIGNANT VESICLE.

Read before the Norfolk (Mass.) District Medical Society, Jan. 13th, 1869, by SILAS E. STONE, M.D., of Walpole.

UNDER the title of malignant pustule I reported to this Society, last winter, eight cases, which were subsequently published, by request, in the Boston Medical and Surgical Journal, Feb. 13th, 1868, p. 19. I have now five more similar cases, of which the following is a brief synopsis.

CASE IX.—May 20th, 1868. C. B., aged 16. Right side of throat much swollen. Throat sore. Small, dark-brown slough, surrounded by minute yellow vesicles, about an inch below the angle of jaw.

21st.—Nausea noticed.

22d.—Much worse, but has rested some with an opiate. Thirst urgent. Swelling increased, extending to the chest, in front and back. Nausea increased. Pulse 100 and feeble.

23d.—Rested better, with opiate. Nausea less. Has retained some nourishment. Pulse the same.

24th.—Rested without opiate. But little nausea. Has retained all nourishment. Thirst less. Swelling and soreness less. Pulse 84, stronger.

25th.—Slough dry, but not separated. Patient convalescent.

CASE X.—June 15th, 1868. T. C., hair worker, 35 years. Was called on account of swelling of the neck of the patient, and his feeling sick and unable to work. Found him sitting up. Pulse 95. Right side of neck much swollen. Says he has no pimple or sore spot, but on careful search two malignant pustules were found in the hairy scalp, one about an inch below the occipital prominence, and the other three-fourths of an inch above it. The swelling extends down to the shoulder, and within three inches of the nipple. Says he was taken sick on Saturday, 13th, with chills and de-

bility. 6, P.M., one def. at noon. Now has severe pain in abdomen. Tongue not remarkable. Pulse 106. Thirsty and perspiring through the day, which was very hot. Still sitting up.

16th.—Pulse 93, and not as strong. Swelling enormous, down to spine of scapula behind; to the nipples, and three inches to left of sternum in front. No headache; no nausea; no delirium. Thinks he did not sleep four hours. Was restless. Now skin bathed in perspiration. The pustules not materially enlarged. Before evening the case passed out of my hands into that of an irregular practitioner, but I was informed by the wife that the patient vomited most of the next day; suffered greatly from epigastric distress, and died early on the morning of the 18th. Ecchymoses appeared after death. Treatment—tincture of iodine locally, and tonics internally, with nutritious diet.

CASE XI.—Nov. 1868. E. W., 32, widow, and has six children. Came to my house. Has been ailing several days. Noticed a pimple over middle of the sterno-mastoid muscle on Monday, 16th, but kept at work till about an hour before coming to my house. Has had no chills, but does not feel well, and came on account of the swelling of the neck around the pimple, which was not discolored. The swelling was diffuse, but marked, and about three inches in diameter. Pulse 68. The pustule was about the size of a small pea in diameter, and consisted of several yellow vesicles. Neither centre nor base was dark, nor was there any areola.

19th.—Pulse 128. Chill 8, A.M. Restless, dreaming and frightened in night. Slept about one hour. One dejection, yesterday. Swelling increased.

P.M.—Pulse 120. Swelling still increasing. Centre of pustule dark brown, and base of vesicles deep purple. Continuous pain in neck. Blood and serum examined by Dr. R. M. Hodges. Bacterids found in serum, none this time in the blood.

20th. Pulse 90. Slept two hours. Restless, and disturbed with frightful dreams. Has vomited green and frothy matter four times, but nevertheless has retained some nourishment. Has constant pain in head and neck. Size of pustule increased by new vesicles, and is now one inch in length, and one half inch wide. Slough dry and depressed at centre. Swelling of neck increased, extending to top of cheek and down to left breast. Tongue dry at tip. Left tonsil and whole inside of throat swollen. No chill in night. Left lung dull on

percussion throughout. Respiratory murmur less. Moist râles at lower lobe.

P.M.—Vomiting continues. Swelling increases. Voice husky. In swallowing, part of the liquid rejected through nose. Marked epigastric distress. Pulse 100, very compressible. Morphia gr.  $\frac{1}{2}$ .

21st.—Pulse 88. Slept most of night. Vomited but once since seven, P.M., yesterday. Voice better. Countenance cheerful. Tongue clear. No epigastric distress. Pustule increased in width. Now five-eighths of an inch in diameter. No new vesicles. Whole slough dark brown. Swelling softer. Retains nourishment.

P.M.—Dulness continues over whole of left lung; respiratory murmur less audible. Swelling softer, except near pustule, where it is quite firm. Fluid from vesicles turbid and reddish; not clear yellow serum as before. The vesicles have a withered look. No vomiting. Had some refreshing sleep.

22d.—Pulse 75. Slept most of night. Some pain in head and neck. No new vesicles. Bubo at angle of jaw. Line of demarcation perceptible.

27th.—Has continued to improve. Sitting up.

Dec. 4th.—Removed the eschar. The subcutaneous slough was not as defined as the eschar, and has been thrown off in shreds from time to time, until a few days ago. At present the ulcer thus formed has not healed. In this case the bacterids, to which Davaine has called attention, were demonstrated at various times in the serum of the vesicles, but not satisfactorily in the blood, although appearances indicating their presence there were found.

CASE XII.—Dec. 27th, 1867. S. R., 16 years. Works in hair factory. Had been somewhat ill for some days, but had kept at work till six o'clock of the previous evening, and until within a few days had been as well as usual. Did not sleep last night on account of restlessness and epigastric pain. In the morning took salts, which was followed by two dejections. As the pain and distress continued, I was called about five, P.M. Found her in bed, frequently throwing up her arms, tossing from side to side, moaning and sighing. Her mind was perfectly clear, and she even smiled when I spoke to her. There was no pulse at the wrist. Her countenance was of a dusky leaden hue, and, like her hands, was cold and damp. There was some dulness over both backs and mucous râles were heard throughout the lungs. The distress continued with increasing severity until she gradually became unconscious, and died

about half past eight the same evening, three and a half hours after I first saw her. Ecchymoses appeared after death. No post-mortem examination allowed.

CASE XIII.—June 20th, 1868. C. P., 16 years. Has been for a short time at work at the hair factory. His mother called in the evening, stating that her boy had been unwell for three or four days, and had remained at home on that account; but during the time had been about house and out of doors. This morning she had given him a purgative. But as this had not operated, and as he had pain in his bowels, she wished to know what to do. I directed castor oil and hot fomentations. At two the next morning I was called. The pain which he located about the umbilicus had continued and increased in severity, although two liquid dejections had occurred. He was in bed, moaning and tossing about, and constantly throwing up his arms. He did not reply when spoken to, and seemed not to hear. The abdomen was flat on percussion; not distended, but the muscles were rigid. The hands and feet were cool, and there was scarcely any pulse at the wrist. He could swallow, but with difficulty. A large serous discharge passed away unconsciously while I was there. He continued to sink, and died at nine the next morning, seven hours after I first saw him.

*Autopsy*, by Dr. Morrill Wyman, of Cambridge, thirty-two hours after death. Rigor mortis well marked. Shoulders, back of neck, head, and ears, quite purple and uniformly so. Eight to ten ounces of clear, yellow serum removed from abdomen. In iliac fossa peritoneum slightly changed, less polished, with a few capillaries somewhat injected. Ecchymosed patches noticed on ilium and cæcum, most marked within three or four inches of ilio-cæcal valve.

In removing intestines the cellular tissue around head of colon, right kidney, and as high up as the liver was emphysematous. The left kidney was pale, but not diseased; the capsule easily separated. The right kidney, or section, gave some rather dark grumous blood; tubuli distinct, and capsule easily separated. The liver was pale, firm, and of natural size—gall bladder distended with bile. The spleen appeared slightly roughened with whitish dots of lymph; otherwise normal. Pancreas presented nothing noticeable.

The ilium at the junction and involving the ilio-cæcal valve, embracing nearly the whole circumference of the intestines, presented a dark purplish-brown portion, with grayish surface, the dark color extending

through all the coats of the intestine. Above this, for the distance of four or five feet, gradually diminishing in intensity, the solitary glands were extremely prominent, like imbedded shot. They were noticed in the cæcum and in the colon. The mesenteric glands leading from the junction of the ilium and cæcum to about three feet up the ilium, were enlarged, from the size of a pea to that of a hickory nut. The larger glands were dark colored externally, quite firm, and at section appeared mottled with gray. The smaller ones were generally pink in different degrees of intensity. The bladder contained four or five ounces of clear, yellow urine. Stomach not opened.

The lungs were generally soft, and crepitated.

The heart, normal, contained hardly any blood, and but one small clot.

These five, with the eight previously reported, make thirteen cases which I have myself attended. There were three others which did not come under my immediate observation. Thus sixteen cases, in all, have occurred in persons working in or connected with a hair factory in the vicinity.

The first eight cases I called malignant pustule, which they certainly are; but on further consideration, I rather prefer the term malignant vesicle, as given by Tanner in his "Index of Diseases," inasmuch as a form of disease occasionally occurring upon the face has also received the former appellation, though it has little in common with the present affection.\*

From all accounts it is evident that malignant vesicle owes its origin to a specific poison derived from a disease in certain classes of animals. All evidence goes to show also that the morbid material may be communicated to man by the skins or hair of diseased animals on which the poison has been deposited. This is the only way that the occasional appearance of the disease can be accounted for among hair cleansers and workers, as in the instances we have witnessed and reported. From all I can learn, the disease has rarely appeared in this country. The inoculation of putrescent matter fails to account for its introduction.

The disease is very seldom, if ever, communicated from man to man. I have frequently known of patients sleeping with the healthy, but have never seen a case that could be traced from one person to another.

Malignant vesicle, malignant edema, and

\* See a valuable paper in the Boston Medical and Surgical Journal, Jan. 7th, 1869, founded on these cases, by R. M. Hodges, M.D., of Boston.

charbon fever, are the three forms in which the disease usually appears. By some, all three are included in the term charbon; by others, charbon and malignant pustule are accounted synonymous.\* Malignant oedema as a separate affection, I have not seen, but cases XII. and XIII. may rightly, perhaps, be classed as charbon fever.

The disease has a period of incubation, eruption, and intoxication. It is not always easy to ascertain the moment of inoculation; but so far as observed, incubation continues from three to a week.

Malignant vesicle is a virulent tumor, inflammatory and gangrenous, characterized at the beginning by an appearance on the skin of a non-purulent *serous vesicle*, usually having an areola, and thought by some to resemble the bite of an insect. This vesicle is soon converted into an eschar,



bordered by a ring of little vesicles (as indicated in the accompanying figure), resting on an indolent and more or less hard and elastic base. This base is always indurated, but cannot always be traced, on account of the surrounding oedema, which is most marked near the pustule, and decreases gradually, according to distance from it.

In three to five days, if left to nature, signs of reaction may begin, but more often symptoms of general intoxication appear. After general feverishness, with pain in head and back, there comes on epigastric distress, and vomiting of glairy and bilious matter. The bowels are usually constipated. There is also great anxiety and thirst. Intelligence generally remains but little disturbed to the last. When fatal, the disease usually terminates from the sixth to the ninth day.

\* At the Imperial Academy of Medicine, Paris, session August 11, 1858, M. Davaine communicated the results of his experiments upon animals to verify his theory of the identity of charbon and malignant pustule, which he attributes to the introduction of bacterids into tissues, whence they invade adjoining parts and finally become general.

To introduce bacterids without wounding vessels, he used a small instrument heated by boiling water, with which he touched the skin of guinea-pigs. He thus obtained little vesicles, into which he introduced blood containing bacterids from the spleen of an animal dead of charbon.

At first nothing occurred, but the next day one of the guinea-pigs had a vesicle, which in a few hours became a third of an inch in diameter, with a red areola, and contained serosity full of bacterids.

Another guinea-pig, inoculated in the same manner, presented likewise a vesicle filled with bacterids.

This, he thought, demonstrated the identity of malignant pustule and charbon, by the experimental reproduction of malignant pustule by blood of charbon.—*L'Union Médicale*, Aug. 13th, 1858, p. 233.

Malignant vesicle is to be distinguished from herpes, acne, boil, malignant anthrax, —which is of larger size,\* very painful, and shining red—simple erysipelas, common gangrene, and the bites of insects.

Of late much stress has been laid on the appearance of Bacterids in the serum of the vesicles, and in the blood of the patients.† By some experimenters their existence is considered diagnostic of the disease. They are also thought by some to be its communicating element. ‡ However found in some of the cases under my observation, but the relation they sustain to the affection seems to require still further investigation.

As to treatment little need be added to what was said in regard to previously reported cases.‡ Writers recommend excision, actual cautery thoroughly applied early in the disease, caustic potassa, Vienna paste, corrosive sublimate, especially; fomentations; emetics, purgatives, and bleeding; cooling drinks; tonics and stimulants. In all the cases under my care heroic or debilitating measures were abstained from. In case E. W., one of the severest, a favorable change occurred after the hypodermic injection of a quarter of a grain of sulphate of morphia. This was administered more to relieve the intense suffering from epigastric distress peculiar to the disease, and the vomiting, than with an expectation of prolonging life. It was a point of some interest to me that this case, the severest that has as yet recovered under my care, received no local treatment, as I was desirous to watch its progress unmodified by any disturbing application.

OPIMUM AND STRAMONIUM.—Dr. J. F. Treuman was called to see a mother and two daughters. They had had paroxysms of ague, and had taken, as they supposed, fennel seed, but it proved to have been stramonium-seed instead. When first seen, the mother and daughter were raving like maniacs, while the other was rapidly sinking into coma. Tr. opii was at once given, and morphia injected subcutaneously. The youngest girl recovered rapidly, but the others only after having taken several large doses of morphia. The recovery in each case was complete.—*Chicago Medical Journal*.

\* See Dr. Hodges's paper, before referred to.

† See Dr. Hodges's paper, loc. cit., and note from *L'Union Médicale*, in preceding column.

‡ Boston Medical and Surgical Journal, Feb. 13th, 1858, p. 21.

## Medical and Surgical Journal.

BOSTON: THURSDAY, FEBRUARY 11, 1869.

IN compliance with our solicitation that he would supply us with a letter on some current topic in physiology, Prof. JOHN C. DALTON, of New York, has sent us the following, which we take great satisfaction in assigning the leading place in this number of the JOURNAL. We have some reason to hope that this is the precursor of a series of occasional letters from some of the most eminent in various walks of the profession, the efforts to obtain which communications will, we presume, be willingly offset against the labor of composition, or compilation, which we shall thus from time to time escape. And we believe no greater service can be rendered to our readers than in providing that they shall be now and then addressed in these pages by teachers and others who are recognized as among the authorities of this period.

NEW YORK, JANUARY, 1869.

MR. EDITOR.—The most interesting event in the physiological circles of this city for the present month, was the reading of a paper on the Cerebellum, before the New York County Medical Society, by Prof. Wm. A. HAMMOND. The well-known ability of the author, and his especial devotion to the physiology and pathology of the nervous system, made it an occasion of more than ordinary interest for the members of the Society. The paper was a very elaborate one, and went over the entire history of the two principal theories of the function of the cerebellum which have been in vogue, as physiological doctrines, for the last twenty-five years. Of these, the first and oldest was that of Gall, which regards the cerebellum as the seat of the sexual instinct and of the reflex actions necessary to its activity. Notwithstanding some rather plausible considerations advanced by Gall in support of this doctrine, other facts, drawn both from comparative anatomy and from pathological observations, are so unmistakably opposed to it, that it has been for some years practically abandoned.

VOL. III.—No. 2a

Prof. Hammond presented all these conflicting facts in detail, and showed clearly that the theory of Gall had not been rejected by physiologists without good reason.

He then passed to the history and discussion of the theory of Flourens; viz., that the cerebellum is the seat of a coördinating power for complicated muscular actions. This still remains the debatable ground on which the discussion of the cerebellar functions must be mainly carried on. For however differently the experiments of Flourens may be interpreted by various writers, their direct results have never been in the least degree invalidated since he first announced them in 1842. In fact, there is hardly any phenomenon which follows more distinctly or more certainly upon any experiment upon the nervous system, than the irregularity of the voluntary movements always produced by injury or destruction of the cerebellum. Prof. Hammond, however, cited at length the singular facts which have been observed since the discovery of Flourens; viz., that birds which have lost their power of coördination owing to removal of a portion of the cerebellum, may *again recover* this power without the re-production of the missing nervous substance. This has been proved in repeated instances by keeping the subjects of the experiment until nearly or completely recovered, and then killing them and examining the condition of the mutilated parts. It is thus shown that a pigeon, with only one half or one third of his cerebellum remaining, may still be able, at last, to coördinate his muscular action sufficiently for all ordinary purposes.

How is this to be accounted for? No doubt it is because the effect of an operation on the cerebellum is not wholly due to the simple loss of its substance, but partly, at least, to the shock or temporary violence inflicted on the cerebellum as a whole. If the animal survives, he may recover from the temporary effects of the shock, and retain only the permanent deficiency due to loss of substance. This deficiency may not be observable in the more simple acts of standing, walking, &c., but in the more extraordinary exertions which



call forth all the combining power of which the nervous centre is capable.

Prof. Hammond, however, believes that the immediate effect of shock upon the cerebellum is the only one which gives rise to the phenomena observed in these experiments. He thinks that injury to the cerebellum produces a state of vertigo; and that the subsequent irregularity of the voluntary motions is due to this condition alone. Perhaps the most noticeable point in his paper was the distinction thus drawn between the actual loss of coordinating power and the condition of vertigo, by which it is temporarily disturbed.

No doubt this distinction is a sound one. A man may lose the power of coordinating his muscles, and thus be unable to direct his foot or his hand to a particular spot, although he may know exactly where that spot is. On the other hand, he may lose the power of judging correctly of the distance and direction of an object, and thus be unable to reach it because he is deceived with regard to its position, the power over his muscles remaining unimpaired. This is the condition of vertigo, such as occurs in intoxication, and as a result of some accidental injuries to the head. The question therefore remains, to which of these causes shall we attribute the irregularity of movement observable after injuries of the cerebellum?

In the discussion which followed the reading of Dr. Hammond's paper, it appeared that all were not prepared to decide positively on this point. The definite and uniform results thus far derived from experiments on the cerebellum, and the peculiar and striking character of the phenomena produced by them, have made a very strong impression on the minds of physiologists. They cannot easily avoid the conclusion that in the cerebellum there resides, either a power of coordination proper, or else a nervous endowment which enables the individual to appreciate correctly the distance and direction of neighboring objects; and that one or the other of these faculties is suspended or disturbed by any injury inflicted on this portion of the brain.

After all, the greatest difficulties in the way of a positive doctrine of the cere-

bellar function are those presented by the results of pathological investigation; for it would almost seem as if each successive theory had been met, in its turn, by some case of disease, degeneration or atrophy of the cerebellum, without any marked disturbance of the functions attributed to it. In the estimation of Prof. Hammond, these cases are damaging and even fatal to every received doctrine of the present day. It is always a good thing to have our opinions overhauled from time to time, and summoned anew to the bar of criticism by such a *résumé* as that given in his paper.

J. C. D.

#### COHNHEIM'S ALLEGED DISCOVERY.

In the *Dutch Archives of Medical and Natural Sciences*\* (as we learn through the *British and Foreign Medico-Chirurgical Review*), Dr. Koster treats of Cohnheim's alleged "discovery," by which pus globules outside of the capillaries are made out to be white corpuscles of the blood which have emerged through orifices in the capillary walls. Dr. Koster appears to think this "discovery" to be quite established; and goes on to say, "if we should soon succeed in obtaining a more positive and distinct explanation of the origin of the change of the circulation of the blood, as a starting-point for inflammation, a great light will undoubtedly be shed by the facts discovered in late years upon a process of which we may, in general, assert what Cruveilhier said of phlebitis in particular, '*qu'elle domine toute la pathologie*.'" That is to say, as Dr. K. seems to suggest, a person is exposed, while heated, to a draught of cold air, and has, within a few days, a pneumonia. Between the chilling process and the inflammation there is a hiatus in science.

We learn, however, through the *Archives de Physiologie, &c.*, of Dr. Brown-Séquard, that Prof. K. Balogh, of Pesth, denies the accuracy of Cohnheim's conclusions relative to the white corpuscles. Repeating the experiments of the latter, Prof. Balogh readily perceived the white globules collect at certain points of the vessels, particularly at the origin of the ramifications; but, in spite of the closest attention, and although

\* Conducted by Donders, Koster and others.

the experiment was often watched for more than twenty-four hours, he never saw a white corpuscle on its way through the walls, or having emerged. He considers the views of Waller, as reproduced by Cohnheim, the result of optical error. He does not positively deny the existence of openings in the walls of the vessels, but is convinced that those openings are only large enough to allow the passage of fluids. He thinks the white globules found in the vicinity of the vessels are produced by the multiplication of cells of connective tissue.

#### THE SUPERINTENDENT OF THE INTERNAL HEALTH DEPARTMENT.

ALMOST at the last moment before going to press, we are apprised that the election of a Superintendent of Health is soon to be acted upon by our City Government. Were there time to bring the attention of our profession to the matter, we are sure there would be a universal call for the appointment of a medical man, and one of high standing, to the office. It is mortifying to recollect that Boston—which has flattered herself that she was a model city in all municipal arrangements—is behind New York—which we usually look upon as displaying all possible mismanagement in the administration of her affairs—in the regulation of the Internal Health Department. The latter city has done a great work in the past three years through the Metropolitan Board of Health, with Dr. Edward Dalton as Sanitary Superintendent, having a corps of medical officers responsible to him. It is time we protected the lives of our citizens in a similar manner.

When the recent epidemic of cholera was expected, it was feared that New York would be a favorite victim of the devouring pestilence. But, when the cholera came, it found the great metropolis unusually cleanly, and that city was, we believe, among those which suffered least in proportion to size and density of population. The purification of New York was the result of the vigorous and intelligent efforts of Dr. Dalton and his assistants.

Every large town in England, we are informed, is protected by a medical man clothed with large powers by act of Parlia-

ment, for the exercise of which authority he is held responsible.

Our City Physician does not control the Department of Internal Health, and the way in which the conduct of that department has been administered under the late *régime* has been far from satisfactory to some at least who are good judges of what ought to be. Let us hope that heed will be given in time to the recommendation of one at the head of our municipal government, and the health of our citizens placed under the ward of members of a profession which should best know the requirements of public hygiene.

We have received from our friend, Dr. Buckminster Brown, a handsomely bound copy of his paper read at the last meeting of the Massachusetts Medical Society, being a collection of cases in Orthopædic Surgery. Appended to the letter-press is a series of finely executed plates representing specimens of club-feet and other distortions; also the results of operations. It is a satisfaction to belong to a profession, one branch of which can so convert deformity into symmetry.

"ARGENTO-ALBUMINURIA."—Under this title is described a disease resulting from the medical use of nitrate of silver, observed by Lionville and Vulpian. The kidneys, upon section, appeared as if sprinkled with fine black or bluish dots, which, in fact, are the Malpighian bodies stained by deposited oxyd of silver. The patient (for but one case is mentioned) had taken in all about one hundred grains of the nitrate, during a period of over eight months, five years before her death. The edges of the gums, the choroid plexus, and the supra-renal capsules were also discolored. Most of the tissues of the body may be similarly affected.—*Allg. Wien. Med. Ztg.*, Jan. 5.

Such of our readers as choose to make the experiment, may observe the process of discoloration under the microscope. By adding a weak solution of the nitrate to a group of epithelium cells, their edges may be seen undergoing discoloration.

D. F. L.

COMPRESSION OF THE ABDOMINAL AORTA.—In a case of cicatricial contraction of the vagina, Dr. Nagel employed a modification

of Dieffenbach's plastic operation; dividing the old cicatrix, he transplanted in between its cut edges a portion of skin from the perimium. On the fifth day arterial hæmorrhage occurred; this was repeated on the eighth, when, other modes of arresting it being impracticable, forcible compression of the aorta by the hands was resorted to, with perfect success.—*Ibid.*

We do not find it stated how long compression was maintained. D. F. L.

**BANTING'S SYSTEM AS A CAUSE OF BRIGHT'S DISEASE.**—Dr. Th. Clemens, of Frankfurt a.M., relates three cases of his own, in which the patients had carried Banting-ism to an excess. So insidious was the invasion of the renal disorder, that when the patients first applied for medical aid the symptoms of Bright's disease, fully developed, were found in each instance. All the cases were fatal, and each was accompanied with a rapid and profound degeneration of the whole system, associated with symptoms referred to the brain and cord.

Dr. C. believes that a tendency to the disease is caused by the loss of the fat of the kidney, together with an excessive supply of albuminous material in the blood.—*Deutsche Klinik*, Jan. 2. D. F. L.

**CASE OF TWINS.**—The mother, in the fourth month of pregnancy, had "a surgical disease of one leg," and at the full term was delivered of twins; one a living, full-grown fœtus, the other dead, and of little more than three months' development. The latter was adherent to the placenta of the living child, but had a separate amnios of its own; was not macerated, but "mummified." Its death was ascribed to the disease of the leg.—*Allg. Med. Centr. Ztg.*, Jan. 6. D. F. L.

#### EXTRACTS FROM FOREIGN MEDICAL JOURNALS.

**Professor Owen's Conclusions on the Origin of Species and Nature of Life.**—We showed in a former article that Professor Owen is no votary of the Divinity of Chance. On the contrary, he believes that as every individual animal passes through a succession of forms—embryonic, infantine, adult, and aged—so each group of similar animals descended from common parents, which we call "species," has an innate and fore-ordained tendency to deviate from the parental type, and to produce new forms of a more specialized character. "A purposive

route of development and change, of correlation and interdependence, manifesting intelligent Will, is as determinable in the succession of races as in the development and organization of the individual. Generations do not vary accidentally in any and every direction, but in preordained, definite and correlated courses."

And as with the coming in of new species, so with the extinction of old ones; if the one cannot be believed to be due to fresh acts of miraculous creation, so must the other not be considered due to occasional cataclysm or convulsion, but to the steady operation of law. One cause of extinction recognized by Professor Owen is defeat in the struggle for existence. In 1850 he had shown this, when he said that, in a dry season, the large mammal will suffer from the drought sooner than the small one; if food be scanty, the large one will perish before the small one; if new enemies be introduced, the larger and more conspicuous will be the earlier victims; and smaller animals are, as a rule, more prolific than large ones.

As a test of the theories which account for the origin of species, Professor Owen brings forward the coral. The species of existing *anthozoa* cannot be traced very far back; those with a flexible or with a branched calcareous axis begin only at the tertiary period, and of the genera of eocene lamellate or stony corals all the species are extinct, and have been superseded in their grand and useful operations by those now forming reefs and atolls. As we extend our researches back in time, we find generic and family types of coral polypes passing away; and that the prevalent pattern of stellate cups of rays of six or its multiples has superseded a similar pattern of four or its multiples.

Now, taking these facts, Professor Owen asks whether a direct act of miraculous creation must be invoked to account for each successive species of coral. Such an idea he dismisses as contrary to the worthy conception of an all-seeing, all-provident Omnipotence. It is not, he says, above, but against reason.

Let us, then, assume that the modern are the direct descendants of the ancient corals, and with Professor Owen "test the propounded explanations of their origin by secondary law." That of appetency is untenable, because a coral polype cannot exercise volition. Lamarck's creative machinery can only be applicable to creatures high enough to "want to do something." Is there any difference in the "ambient

medium"? We have no knowledge that the polypes of the Devonshire or Cambrian hills worked in an ocean different from the present, or that, if different, it could change a quadripartite into a sexpartite disposition of the coral cells. The "personifying the fact of such transmutations by the term 'Natural Selection' gives no more insight into the manner of the operations than we learn of that of the budding out of a new leg in a maimed newt by being told that it was done by the "nisus formativus," or by "pangenesis"!

Professor Owen sums up the contrast between his own theory of "Derivation" and Darwin's theory of "Natural Selection" in few words, which we thus venture to abridge. "Derivation" holds that each species changes in time by virtue of inherent tendencies. "Natural Selection" holds that this is effected by altered external circumstances. "Derivation" sees the purpose of the Creator in the variety and beauty of creation, and the adaptation of each member of it to others, and especially man, a being capable of appreciating beauty. "Natural Selection" feels that if ornament or beauty in itself should be a purpose in creation, it would be absolutely fatal to it as an hypothesis. "Natural Selection" leaves the origin and succession of species to the fortuitous concurrence of outward conditions. "Derivation" recognizes purpose. . .

Professor Owen, dismissing the old doctrines as absurd, and Darwin's pangenesis as absurder, believes to the full in what has been called "spontaneous generation," or the incessant new development of living beings out of non-living material. He sides with Pouchet and Child against Pasteur. He does not believe in "panspermism," or the doctrine that all the forms of life produced in decaying organic matter come from germs dispersed through the air. He prefers believing that, when the requisite material and conditions are present, other forces are resolved into vital force; and sees "the grandeur of creative power," not in the exceptional miracle of one or few original forms of life, but in the "daily and hourly calling into life many forms by conversion of chemical and physical into vital modes of force." The "CAUSE which has endowed His world with power convertible into magnetic, electric, thermotic, and other forms or modes of force, has also added the conditions of conversion into the vital mode." "Change of force forms part of the constitution of the Kosmos."

We will not follow Professor Owen minutely in the comparison which he draws

between life and magnetism, and between all the actions of living beings, from the attraction of the amoeba by a bit of meat to the highest phenomena of consciousness in man; of which his conclusion is that from the magnet which chooses between steel and zinc to the philosopher who chooses between good and evil, the difference is one of degree, not of kind, and that there is no need to assume a special miracle to account for mental phenomena.

Although these ideas must fairly be called materialistic, and openly oppose the notion of an "immaterial indestructible soul," yet nothing can be further from Professor Owen's doctrines than the low materialism which sees law without a law-giver, force without an author, and no God apart from matter. It must be remembered in the first place that Professor Owen's ideas of life necessitate the belief in the perpetual presence and working of a personal God, the Lord and Giver of life; that he believes in a future life and resurrection and judgment of the dead, "on the ground of their being parts of a Divine revelation;" and that he shows (and quotes the history of the witch of Endor and of the doubting apostle Thomas to exemplify it) that we really are in no condition to say what is material and what immaterial. We only know of force and its effects, but (as Faraday said) as for what causes these effects we get nothing by defining them as material or immaterial. For our own parts, we must not wander into the ground of dogmatic faith, but, as regards reasonable opinion, we must say that Professor Owen's own doctrines tell quite as much for the existence of an immortal soul as not; that the results of force must be as indestructible as matter, save by the will of God, and soul is one mode of force; and, if the matter be doubtful, we ourselves are not ashamed to be biassed by the spiritual instincts of universal man, and to say, with the Pagan philosopher, "*Si in hoc erro, quod animos hominum immortales esse credam, lubenter erro, nec mihi hunc errorem quo delector dum vivo extorquei volo.*"—*London Med. Times and Gazette.*

#### On Craniotomy and Cæsarean Section.

By THOMAS RADFORD, M.D.—

Some writers who advocate and sanction craniotomy in cases of extreme pelvic distortion have never performed the operation, nor ever even witnessed a labor which was thus obstructed. Some of them, however, have the candor to acknowledge their want of personal experience. Although it is so positively stated than a mutilated full-grown

infant can be brought through the minimum of pelvic space, can we be assured that this operation can be safely performed? and is there not quite as much danger to the life of the woman as is incurred by the Cæsarean section? I have not the least doubt there is quite as much risk to the life of the mother from craniotomy performed in the higher degrees of pelvic distortion, as there would be from Cæsarean section—both operations being freed from the contingent mischief produced by protracted labor. Writers of great eminence entertain the same opinion.

Can the dimensions of the pelvic apertures be ascertained with such mathematical accuracy as to justify the practitioner in having recourse to craniotomy in the more extreme cases of pelvic distortions? From my own long and extensive practical experience I am firmly convinced that it is impossible to ascertain with precision the exact degree of pelvic contraction in such cases as those in which a very small fractional mistake makes the difference between life and death of the woman. Even in the lighter shades of pelvic distortion it is quite impossible to compute the exact measurements. My opinion is substantiated by our best writers and able practitioners. Practical results also corroborate the above statement.

Many cases are recorded in which the head of the infant has been opened by obstetricians of high rank, but who have afterwards been unable to deliver the woman; the patients have been left to die after the infants had escaped into the abdomen through a laceration in the uterus. I have met with cases of this kind. One is recorded in the London *Obstetrical Transactions*, vol. viii. p. 158. In some other cases abdominal section has been performed in order to extract the mutilated infant. A dogma in obstetrics is sometimes highly dangerous to set forth, especially if practice based upon it leads to the sacrifice of life.

It is stated, if there be a space in the antero-posterior conjugate diameter of  $1\frac{1}{2}$  inch, and a transverse diameter equal to 3 inches, the base of the head of a full-grown infant, face brought first, can be dragged through the pelvis. I deny the truth of this statement, unconditionally put forth as a general rule, regardless of the kind of distortion or the parts of the pelvis involved in the mischief.

I have attempted to introduce Dr. B. Hicks's cephalotribe into a cast of the pelvis, but I found it quite impossible to place it within the cavity in its unexpanded state,

much less to open it for the purpose of embracing a head for the purpose of crushing it. . . . . *Ibid.*

Accounts of men with tails have been helping to fill the columns of the daily papers during the Christmas holidays. Many of these stories have taken their origin from monstrosities with spina bifida. To adorn a tale and to be adorned by a tail are two things which differ in frequency. We should like to see a specimen.—*Ibid.*

The *Moniteur* recently contained an account of the discovery by a M. Bertrand of a quantity of fossil human remains in quaternary drift. The remains were discovered in the Boulevard St. Pol, at Clichy, in a sandpit at the depth of seventeen feet, and covered by layers of humus, red sand, five of yellow sand or loess, the latter alternating with four of clay. The last bed of loess rested on the drift. The bones were associated with those of elephant, rhinoceros, hippopotamus, stag, horse, and ox. The skulls found were wedge-shaped and dolichocephalic, the forehead narrow, the cheek-bones very prominent, the occipital foramen very far back, and the meatus auditorius very horizontal.—*Ibid.*

*Apropos* of education, we noticed a sensible letter from Mr. Henry Hayman in the *Times* of Saturday last. Its immediate object is to point out the claims of geology as a branch of natural science the most fitted for the purposes of study in schools. On this he discourses ably and well. But the point to which we would draw attention is his testimony, founded, as he says, on several years' experience in more than one post of chief responsibility, that natural science is no cure for dulness in the pupil, nor has it any special aptitude for bringing out faculties which have lain dormant in other lessons. He gives the palm to studies which are distinctively human in their interest, such as language and mathematics, as the corner-stone of solid education. He maintains that they are fitted in general to invigorate, concentrate, and regulate the forces which lie within the mind itself. We heartily agree with him.—*Ibid.*

*Sanitary Character of Andine Heights.*—Dr. John H. Scrivener, having recently returned from South America, where he practised for many years as a physician in Potosi and other cities in Bolivia, and in the Argentine Republic, has, in a small pamphlet with the above title, recently published, directed the attention of the Profession and of the general public to the re-



markable salubrity of the climate in the mountainous regions of these fine countries, as indicated by the entire absence of pulmonary consumption among the natives, and the great benefit that has been derived by many invalids from the coast and from distant countries when they have resided there for some time.

Dr. Archibald Smith, in his essay on the "Climate of the Swiss Alps and of the Peruvian Andes Compared," remarks that "incipient tubercular phthisis is one of the most common pulmonary affections known in Lima and other parts of the coast of Peru. The disease is almost certainly cured, if taken in time, by removing the patient to the open inland valley of Jauja, which is from ten to eleven thousand feet above the level of the sea." The experience of Dr. Scrivener in respect of the Andine heights of the regions to the south of Peru, and especially of the mountains of Cordova, fully confirm the statements of Dr. Smith. With a marked hereditary tendency to consumption himself, having lost two brothers and two sisters from the malady, he can testify strongly to the good effects of the climate upon himself, independently of what he observed in the case of others.—*Ibid.*

The Paris *Almanach de Médecine* for 1869, the nearest approach to the London Medical Directory (for there is no general Medical Directory for France), furnishes some figures that may be of interest. The *Almanach* first gives an account of the course of study to be pursued by students, and of the laws regulating the profession. The medical student must, before he makes his inscriptions, have obtained the diplomas of the Baccalaureat-ès-lettres and -ès-sciences, the first costing him 100 and the second 50 fr. For his purely medical studies he has to make sixteen inscriptions during the four years over which these are continued, the entire expense necessary for obtaining his Doctor's diploma being 1272 fr., to which 150 fr. of optional expenses for special advantages may be added. The diploma of the *officier de santé*, or medical practitioner of an inferior class, educated in the provincial schools, and confined in his practice to the department he selects, costs 848 fr. There are in France three Faculties of Medicine. That of Paris, has 6 Honorary Professors, 27 Professors, and 26 *agrégés* or Assistant Professors; the number of doctors admitted from 1798 to 1867 inclusive was 17,190—282 having been admitted in 1867.

The total number of Doctors practising in Paris is 1567, to which are to be added

295 *officiers de santé* and 547 *pharmaciens*. As exhibiting the great difference which prevails in France as to obstetrical practice, as compared with this country, we may observe that the list of licensed midwives given amounts to the formidable number of 764. It is to be recollected, however, that the law compels these women to call in a Doctor of Medicine on the necessity arising of any instrumental interference. . . . . *Ibid.*

At the Annual Congress of German Naturalists and Physicians, in Berlin, Dr. Jürgensen, of Kiel, communicated his observations on the administration of quinine in febrile diseases, saying that this drug had the power of lowering the fever heat, and that this was done by the agency of the nervous system. Dr. Binz, of Bonn, spoke on the antiseptic effects of quinine, and maintained that the drug had no direct effect on the nervous system, but altered the composition of the blood, and that its nervine effects were only secondary.—*Ibid.*

*Treatment of Sea-sickness.*—M. le Coniat, a medical officer of the French Marine attached to the service of the Transatlantic mail packets, states that, after trying the usual remedies, he has since 1865 employed faradisation of the epigastrium in combination with an application of a solution of the sulphate of atropine (two or three centigrammes to 50 grammes), and that this means has proved successful in the great majority of several hundred cases of both sexes in which it has been tried. He thinks that during the first day the vomiting should be allowed to have its free course. He says that he has only met with five cases of abortion during his thirty-eight crossings, and that, in this, opium is just as useful as it is useless in sea-sickness. Women usually, in these voyages, have their menstrual periods hastened forwards by some days, and some even by two or three weeks. Others, again, suffer from genetic excitement, for which the bromide of potassium may be given.—*Ibid.* from *Archives de Méd. Navale*, November.

THERE were 108 deaths in Providence, R. I., during the month of January. Just one third of all the deaths in the month, in the whole city, were in the First Ward, and one third were from scarlatina. After an almost entire absence of mortality from scarlatina for two years, it began to be prevalent early in 1868. The epidemic will undoubtedly spread through the city, growing less severe in warm weather.

## Medical Miscellany.

We have received from Dr. Toner, of Washington, a notice of the "Dedication of the Hall of the Medical Society of the District of Columbia." We make the following extracts:—

"On Wednesday evening, the new hall of the Medical Society of the District of Columbia was dedicated with appropriate ceremonies. The hall, which has just been completed, is located on the south side of F Street, west of Tenth Street, and is one of the finest in the city. The building is three stories high, with a handsome pressed-brick front. The first story embraces two very fine stores, with large plate-glass windows, and the third story is divided into lodging rooms, connecting only with the adjoining building on Tenth St. But the main feature—that for which the building was put up—is the hall, on the second floor, which fronts 46 feet on F Street, with a width of 36 feet; and adjoining it on the rear are a committee room, 14 by 23, and a library room, 18 by 20 feet. The hall is reached by a commodious stairway and passage, and the entire building is completed with all the improvements modern art could suggest.

"Dr. Wm. P. Johnston was introduced to the audience as the representative of the building committee.

"The objects of the Society in creating this building, he said, were six:—

"1. The advancement of medical science.  
"2. The cultivation of a taste for medical literature.

"3. The establishment of more social and fraternal feeling among its members.

"4. The promotion of that strict morality which our vocation inculcates, and the development of that exemplary and high-toned professional character to which the medical man should ever seek to attain.

"5. The establishment, under the direction of this Society, of a dispensary for the city of Washington.

"6. The accomplishment of the great end for which the medical art is cultivated, which is to secure in the best possible way the interest of the public by raising the standard of medical learning, and by cultivating those graces and ornaments which render the medical man most acceptable and useful in his relations to the public."

Dr. J. M. Toner, the librarian, in course of some extended and instructive remarks, on behalf of public professional libraries, said:—

"Philadelphia has three medical libraries, and the combined number of volumes is about 55,000. The oldest, the Pennsylvania Hospital Library, was founded in 1762, and has now over 30,000 volumes, including pamphlets. The College of Physicians, so richly endowed a few years ago by Dr. Thomas D. Mutter, has nearly 20,000 volumes, including pamphlets, and is the most complete working medical library in our country."

Dr. T. adds, in a private note to us:—"I suspect that we are the first Society without some bequest that has expended so much for its comfort and convenience, and for the benefit of future

generations of physicians. The whole outlay will be about \$40,000."

We learn from the *Union Médicale* that at the election on Monday, the 4th of January, of a member at large of the Academy of Sciences, in the place of M. Delessert, the friends of M. Ricord were disappointed. It was M. Duméril the younger who obtained the majority of votes.

THE sad announcement comes from Vienna, through the *Union Médicale*, that Professor Skoda is affected with an organic disease which threatens his life.

## MEDICAL DIARY OF THE WEEK.

MONDAY, 9, A.M., Massachusetts General Hospital, Med. Clinic. 9, A.M., City Hospital, Ophthalmic Clinic.

TUESDAY, 9, A.M., City Hospital, Medical Clinic; 10, A.M., Surgical Lecture. 9 to 11, A.M., Boston Dispensary. 10-11, A.M., Massachusetts Eye and Ear Infirmary.

WEDNESDAY, 10, A.M., Massachusetts General Hospital, Surgical Visit. 11 A.M., OPERATIONS.

FRIDAY, 9, A.M., City Hospital, Ophthalmic Clinic; 10 A.M., Surgical Visit; 11, A.M., OPERATIONS. 9 to 11 A.M., Boston Dispensary.

SATURDAY, 10, A.M., Massachusetts General Hospital, Surgical Visit; 11, A.M., OPERATIONS.

MR. EDITOR.—In the article on Cutaneous Horns of the Eyelid, in this week's issue, omission is made of a case reported to the Pathological Society of London, Oct. 21st, 1862, by Mr. Canton. This horn was removed by him from the upper lid of a woman aged 70. Its dimensions are not stated. HENRY L. SHAW.

ERRATUM.—In our last issue, page 11, line 5th, for "there" read *here*.

TO CORRESPONDENTS.—The following communications have been received:—Two Cases in Ophthalmic Practice—Atropine in its Physiological Action—Disease of the Supra-renal Capsules—Two Cases of Paralysis of Intrinsic Muscles of the Larynx.

BOOKS AND PAMPHLETS RECEIVED.—Pennsylvania Hospital Reports. Vol. II. 1869. Philadelphia: Lindsay & Blackiston.—A History of the Medical Department of the University of Pennsylvania from its foundation in 1765. By Joseph Carson, M.D. Philadelphia: Lindsay & Blackiston.—Treatise on Diseases of the Ear, including the Anatomy of the Organ. By Anton von Treitschke, M.D., Professor in the University of Wurzburg, Bavaria. Translated and Edited by D. B. St. John Roosa, M.A., M.D. New York: Wm. Wood & Co.—Compendium of Percussion and Auscultation. By Austin Flint, M.D. New York: Wm. Wood & Co.—On the Microscope in the Diagnosis and Treatment of Sterility. By J. Marion Sims, M.D., New York.

DEATHS IN BOSTON for the week ending Saturday noon, February 6th, 103. Males, 54—Females, 51.—Accident, 1—anæmia, 1—congestion of the brain, 3—disease of the brain, 1—inflammation of the brain, 1—bronchitis, 3—burns, 1—cancer, 2—cholera infantum, 1—cholera morbus, 1—consumption, 20—convulsions, 2—croup, 2—cyanosis, 1—debility, 1—diarrhœa, 1—diphtheria, 4—dropsy, 1—dropsy of the brain, 5—eczema, 1—scarlet fever, 13—typhoid fever, 1—disease of the heart, 2—infantile disease, 7—intemperance, 1—disease of the kidneys, 4—congestion of the lungs, 2—inflammation of the lungs, 10—old age, 2—paralysis, 1—premature birth, 1—peritonitis, 1—pharyngitis, 1—puerperal disease, 1—scalded, 1—unknown, 4.

Under 5 years of age, 43—between 5 and 20 years, 20—between 20 and 40 years, 17—between 40 and 60 years, 12—above 60 years, 13. Born in the United States, 75—Ireland, 21—other places, 9.